DELINEATION OF CLINICAL PRIVILEGES - NEUROSURGERY

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

PROVIDER CODES	APPROVAL CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support	5 - Not approved, insufficient facility support

SECTION I - CLINICAL PRIVILEGES

Category I. Privileges in this category are for uncomplicated surgical illness or problems that present no serious threat to life. When doubt exists regarding diagnosis, or in cases in which improvement from treatment is not soon apparent, consultation will be sought. Category I privileges may be granted to physicians without formal surgical training based on documented evidence that such privileges have been previously and successfully exercised.

Requested	Approved	
		Category I clinical privileges

Category II. Includes Category I plus specific surgical conditions and procedures of increased scope and complexity that may require general and conductive anesthesia, but do not constitute an immediate or serious threat to life. Providers with these privileges are expected to request consultation when expected improvement is not soon apparent and when specialized therapeutic or diagnostic techniques are indicated. Category II privileges may be granted to those providers who have satisfactorily completed at least one year post-PGY1 formal training in surgery, or whose skills have been verified and maintained through experience.

Requested	Approved	
		Category II clinical privileges

Category III. Includes privileges in Categories I and II plus those associated with complex or severe illness or general surgical problems, and those with an immediate or serious threat to life. Physicians with these privileges may act as consultant to others and may, in turn, be expected to request consultation when: (a) the diagnosis and/or management remains in doubt over an unduly long period of time, especially in the presence of a life-threatening illness; (b) unexpected complications arise that are outside the provider's level of competence; or (c) specialized treatments or procedures are contemplated with which the provider is not familiar. Category III providers are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training and, except under unusual circumstances as determined by the Credentials Committee, sufficient for board certification.

Requested	Approved	
		Category III clinical privileges

Category IV. Includes privileges in Categories I, II, and III to the extent that qualification criteria are met, plus those associated with illnesses and surgical problems requiring an unusual degree of expertise and competence. Providers with these privileges have the highest level of competence within the field of neurosurgery and are qualified to act as consultants and should likewise request consultation from within or from outside the hospital staff whenever needed. Practitioners with these privileges are expected to have training and experience considered appropriate for a sub-specialist and, except under unusual circumstances as determined by the Credentials Committee, sufficient for subspecialty board certification.

Requested	Approved	
		Category IV clinical privileges

PRIVILEGES

Requested	Approved	
		a. Percutaneous stereotactic/endoscopic approaches to the spine, including but not limited to, excision/discectomy of the lumbar and/or cervical spine; including chemoneucleolysis and placement of hardware.
		b. Introduction of intracatheter or catheter, venous unilateral or bilateral, including but not limited to, the superior or inferior vena cava, right heart or pulmonary artery for critical care management of complex neurosurgical disease process(es).
		c. Introduction/puncture of artery for catheterization or cannulation for sampling, monitoring or infusion for critical care management/monitoring of complex neurosurgical disease process(es).
		d. Puncture of the skull, meninges, and/or brain for injection, drainage, diagnostic monitoring, aspiration to include but not limited to, subdural taps, ventricular puncture, cervical, lumbar and sacral cisternal areas, to include shunt systems for therapeutic and/or diagnostic reasons.
		e. Twist drill, burr hole or trephine of the cranial vault for diagnosis, implantation, evacuation and/or drainage for tumor, trauma, infection and/or congenital/acquired disorders of the central nervous system.

PRIVILEGES *(Continued)*		
Requested	Approved	
		f. Craniotomy, craniectomy (supratentorial and/or infratentorial) for tumor, trauma, infection, hemorrhage, decompression and congenital/acquired disorders of the central nervous system and skull, with or without incision and/or removal of brain/skull tissue.
		g. Craniotomy, craniectomy, plastic reconstruction, remodeling with autologous and/or non-autologous materials/implants/grafts of cranium and/or cranial base for craniosynostosis and/or craniofacialdysostosis, including but not limited to named syndromes.
		h. Transsphenoidal and/or transoral approach to the skull base, upper cervical spine, sella turcica, parasellar and suprasellar areas for tumor, trauma, infection, hemorrhage, decompression and/or congenital/acquired disorders.
		i. Surgery of cerebral/spinal aneurysm, arteriovenous malformation and/or angioma, with or without intraoperative angiography, with or without intraoperative embolization, with or without intracranial-extracranial arterial anastomosis.
		j. Stereotaxic/endoscopic biopsy, excision, drainage, puncture, injection (supratentorial and/or infratentorial) for tumor, trauma, pain, movement disorder, infection, hematoma, hemorrhage, and/or congenital/acquired disorders, with and without CT/MRI assistance/guidance, with or without creation of neurolytic lesion.
		k. Repair and/or debridement of skull fracture with or without dural/brain injury; encephalocele without cranioplasty; post-traumatic and/or postoperative cranial defects with autologous and/or non-autologous material/implants/grafts, to include scalp avulsions/defects by full thickness, split thickness, rotation and/or pedicle grafts.
		l. Therapeutic injection of medications, pharmaceutical agents and/or drugs: subcutaneous(SC), intramuscular(IM), intravenous(IV), intraventricular, epidural or subarachnoid space.
		m. Injection for myelography and/or discogram; trigger point therapy and/or facet injection of steroids and/or local anesthetic agents.
		n. Incision, drainage, puncture, aspiration of hematoma, abscess, cyst or infection of the skin and subcutaneous tissues, including removal of foreign body.
		o. Biopsy, debridement and excision with closure of the scalp, skin, subcutaneous tissue and muscle to include care of decubitus ulcers.
		p. Repair, simple or complex, with/without cutaneous transfer and/or pedicle flaps of the scalp and paraspinal cutaneous tissue.
		q. Application of cranial tongs, stereotactic frame and Halo device, to include management and application of external orthosis of the cervical, thoracic, and lumbar spine.
		r. Management/treatment of closed skull fracture, diffuse brain injury, cerebral contusion, cerebral concussion without operation.
		s. Management/treatment of closed spinal fractures with/without neurologic impairment without operation.
		t. Anterior approach (partial/complete) resection of vertebral component of the cervical, thoracic, lumbar and/or sacral spine, single and/or multiple levels, intradural or extradural, for trauma, tumor, pain, infection and/or congenital/acquired disorders (including costotransversectomy and/or corpectomy) with reconstruction by autologous or non-autologous material/implants/grafts.
		u. Arthrodesis, anterior or anterolateral approach, single or multiple levels, cervical, thoracic, lumbar and/or sacral spine for intervertebral disc excision with reconstruction by autologous and/or non-autologous material/implants/grafts.
		v. Arthrodesis, posterior and/or posterior-lateral approach, single or multiple levels, cervical, thoracic, lumbar and/or sacral spine for trauma, tumor, pain, infection and/or congenital/acquired disorders with autologous and/or non-autologous material/implants/grafts.
		w. Posterior approach intradural and/or extradural laminotomy/laminectomy, single and/or multiple levels, for exploration/decompression of spinal neural elements for tumor, trauma, pain, infection and/or congenital/acquired disorders; including excision of herniated intervertebral disc of the cervical, thoracic, lumbar and/or sacral spine.
		x. Spinal instrumentation, anterior and/or posterior, single and/or multiple levels, for arthrodesis (including redo-procedure) for spinal deformity as a consequence of tumor, trauma, infection and/or congenital/acquired disorders including herniated intervertebral disc of the cervical, thoracic and/or lumbar spine with reconstruction by autologous and/or non-autologous material/grafts.
		y. Cerebrospinal fluid diversion, primary and/or revision to venous, pleural, peritoneal or other terminus.
		z. Puncture for injection, drainage, aspiration, rhizotomy: the spinal cord, spinal subarachnoid space, intracranial cisterns for tumor, trauma, pain, infection, hematoma, hemorrhage and congenital/acquired disorders, including but not limited to chemotherapeutic, neurolytic, anesthetic and/or contrast agents.
		aa. Introduction and/or injection of anesthetic, diagnostic or therapeutic agents and/or rhizotomy to somatic, autonomic, cranial and/or peripheral nerves.
		ab. Exploration, neurolysis, neuroplasty (intraneural and/or extraneural), with or without decompression of somatic, autonomic, cranial and peripheral nerves; with and without transection, transposition, or excision; with and/or without neurorrhaphy, with or without autologous and/or non-autologous nerve graft.
		ac. Carotid endarterectomy.
		ad. Stereotactic radiosurgery for treatment of vascular, neoplastic, pain, and movement disorders.
		ae. Arteriography and endovascular treatment of carotid and intracranial vascular disease including but not limited to carotid stinting, coiling aneurysms, and balloon occlusion and dilation, and embolization AVMs.

PRIVILEGES *(Continued)*		
		af. Placement of neurostimulating and monitoring electrodes/probes into or adjacent to the brain, spinal cord, or peripheral nerves for diagnostic and therapeutic purposes, with or without simultaneous placement of permanent stimulator/pump into soft tissue.

COMMENTS

	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

CREDENTIALS COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*

EVALUATION OF CLINICAL PRIVILEGES - NEUROSURGERY

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. PERIOD OF EVALUATION *(YYYYMMDD)* FROM TO
4. DEPARTMENT/SERVICE	5. FACILITY *(Name and Address: City/State/ZIP Code)*	

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

SECTION I - DEPARTMENT/SERVICE CHIEF EVALUATION

CODE	PRIVILEGE CATEGORY	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	Category I clinical privileges			
	Category II clinical privileges			
	Category III clinical privileges			
	Category IV clinical privileges			
	PRIVILEGES			
	a. Percutaneous stereotactic/endoscopic approaches to the spine, including but not limited to, excision/discectomy of the lumbar and/or cervical spine; including chemoneucleolysis and placement of hardware.			
	b. Introduction of intracatheter or catheter, venous unilateral or bilateral, including but not limited to, the superior or inferior vena cava, right heart or pulmonary artery for critical care management of complex neurosurgical disease process(es).			
	c. Introduction/puncture of artery for catheterization or cannulation for sampling, monitoring or infusion for critical care management/monitoring of complex neurosurgical disease process(es).			
	d. Puncture of the skull, meninges, and/or brain for injection, drainage, diagnostic monitoring, aspiration to include but not limited to, subdural taps, ventricular puncture, cervical, lumbar and sacral cisternal areas, to include shunt systems for therapeutic and/or diagnostic reasons.			
	e. Twist drill, burr hole or trephine of the cranial vault for diagnosis, implantation, evacuation and/or drainage for tumor, trauma, infection and/or congenital/ acquired disorders of the central nervous system.			
	f. Craniotomy, craniectomy (supratentorial and/or infratentorial) for tumor, trauma, infection, hemorrhage, decompression and congenital/acquired disorders of the central nervous system and skull, with or without incision and/or removal of brain/skull tissue.			
	g. Craniotomy, craniectomy, plastic reconstruction, remodeling with autologous and/or non-autologous materials/implants/grafts of cranium and/or cranial base for craniosynostosis and/or craniofacialdysostosis,including but not limited to named			
	h. Transsphenoidal and/or transoral approach to the skull base, upper cervical spine, sella turcica, parasellar and suprasellar areas for tumor, trauma, infection, hemorrhage, decompression and/or congenital/acquired disorders.			
	i. Surgery of cerebral/spinal aneurysm, arteriovenous malformation and/or angioma, with or without intraoperative angiography, with or without intraoperative embolization, with or without intracranial-extracranial arterial anastomosis.			
	j. Stereotaxic/endoscopic biopsy, excision, drainage, puncture, injection (supratentorial and/or infratentorial) for tumor, trauma, pain, movement disorder, infection, hematoma, hemorrhage, and/or congenital/acquired disorders, with and without CT/MRI assistance/guidance, with or without creation of neurolytic lesion.			
	k. Repair and/or debridement of skull fracture with or without dural/brain injury; encephalocele without cranioplasty; post-traumatic and/or postoperative cranial defects with autologous and/or non-autologous material/implants/grafts, to include scalp avulsions/defects by full thickness, split thickness, rotation and/or pedicle grafts.			

CODE	PRIVILEGES *(Continued)*	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	l. Therapeutic injection of medications, pharmaceutical agents and/or drugs: subcutaneous(SC), intramuscular(IM), intravenous(IV), intraventricular, epidural or subarachnoid space.			
	m. Injection for myelography and/or discogram; trigger point therapy and/or facet injection of steroids and/or local anesthetic agents.			
	n. Incision, drainage, puncture, aspiration of hematoma, abscess, cyst or infection of the skin and subcutaneous tissues, including removal of foreign body.			
	o. Biopsy, debridement and excision with closure of the scalp, skin, subcutaneous tissue and muscle to include care of decubitus ulcers.			
	p. Repair, simple or complex, with/without cutaneous transfer and/or pedicle flaps of the scalp and paraspinal cutaneous tissue.			
	q. Application of cranial tongs, stereotactic frame and Halo device, to include management and application of external orthosis of the cervical, thoracic, and lumbar spine.			
	r. Management/treatment of closed skull fracture, diffuse brain injury, cerebral contusion, cerebral concussion without operation.			
	s. Management/treatment of closed spinal fractures with/without neurologic impairment without operation.			
	t. Anterior approach (partial/complete) resection of vertebral component of the cervical, thoracic, lumbar and/orsacral spine, single and/or multiple levels, intradural or extradural, for trauma, tumor, pain, infection and/or congenital/ acquired disorders (including costotransversectomy and/or corpectomy) with reconstruction by autologous or non-autologous material/implants/grafts.			
	u. Arthrodesis, anterior or anterolateral approach, single or multiple levels, cervical, thoracic, lumbar and/or sacral spine for intervertebral disc excision with reconstruction by autologous and/or non-autologous material/implants/grafts.			
	v. Arthrodesis, posterior and/or posterior-lateral approach, single or multiple levels, cervical, thoracic, lumbar and/or sacral spine for trauma, tumor, pain, infection and/or congenital/acquired disorders with autologous and/or non-autologous material/implants/grafts.			
	w. Posterior approach intradural and/or extradural laminotomy/laminectomy, single and/or multiple levels, for exploration/decompression of spinal neural elements for tumor, trauma, pain, infection and/or congenital/acquired disorders; including excision of herniated intervertebral disc of the cervical, thoracic, lumbar and/or sacral spine.			
	x. Spinal instrumentation, anterior and/or posterior, single and/or multiple levels, for arthrodesis (including redo-procedure) for spinal deformity as a consequence of tumor, trauma, infection and/or congenital/acquired disorders including herniated intervertebral disc of the cervical, thoracic and/or lumbar spine with reconstruction by autologous and/or non-autologous material/grafts.			
	y. Cerebrospinal fluid diversion, primary and/or revision to venous, pleural, peritoneal or other terminus.			
	z. Puncture for injection, drainage, aspiration, rhizotomy: the spinal cord, spinal subarachnoid space, intracranial cisterns for tumor, trauma, pain, infection, hematoma, hemorrhage and congenital/acquired disorders, including but not limited to chemotherapeutic, neurolytic, anesthetic and/or contrast agents.			
	aa. Introduction and/or injection of anesthetic, diagnostic or therapeutic agents and/or rhizotomy to somatic, autonomic, cranial and/or peripheral nerves.			
	ab. Exploration, neurolysis, neuroplasty (intraneural and/or extraneural), with or without decompression of somatic, autonomic, cranial and peripheral nerves; with and without transection, transposition, or excision; with and/or without neurorrhaphy, with or without autologous and/or non-autologous nerve graft.			
	ac. Carotid endarterectomy.			
	ad. Stereotactic radiosurgery for treatment of vascular, neoplastic, pain, and movement disorders.			
	ae. Arteriography and endovascular treatment of carotid and intracranial vascular disease including but not limited to carotid stinting, coiling aneurysms, and balloon occlusion and dilation, and embolization AVMs.			
	af. Placement of neurostimulating and monitoring electrodes/probes into or adjacent to the brain, spinal cord, or peripheral nerves for diagnostic and therapeutic purposes, with or without simultaneous placement of permanent stimulator/pump into soft tissue.			

CODE	PRIVILEGES *(Continued)*	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE

SECTION II - COMMENTS *(Explain any rating that is "Unacceptable".)*

NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE *(YYYYMMDD)*